Supreme Court, U.S.
FILED

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No.

IN THE

Supreme Court of the United States

KIRK TEDFORD,

Petitioner,

v.

BENCHMARK INSURANCE COMPANY AND THE FUTURE EQUIPMENT COMPANY, INC. EMPLOYEE WELFARE BENEFIT PLAN

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

APPENDIX

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38 pp

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 01-10995

KIRK TEDFORD

Plaintiff-Appellant-Cross-Appellee

versus

BENCHMARK INSURANCE COMPANY; FUTURE EQUIPMENT CO.,

Defendants-Appellees-Cross-Appellants

Appeals from the United States District Court
for the Northern District of Texas
(4:00-CV-1695-BE)

Before WIENER and DENNIS, Circuit Judges, and DUPLANTIER, District Judge. PER CURIAM:

Plaintiff Kirk Tedford was a participant in an employee welfare benefit plan ("the plan") sponsored by his employer, defendant Future Equipment Company, Inc. ("Future Equipment"). The plan is governed by the Employee Retirement Income Security Act (ERISA)(29 U.S.C. §1001 et seq.), and is covered by a group policy underwritten by defendant Benchmark Insurance

Company ("Benchmark"), issued through the National Healthcare Trust, and administered by Corporate Benefits Services of America, Inc. ("CBSA"), an independent third-party contractor which serves as ERISA plan administrator for numerous plans. Discretionary authority for processing and settling claims of participants and beneficiaries under the plan was duly delegated to CBSA.

While covered by the plan, Tedford wrecked his motorcycle in a single vehicle accident at about midnight of the day in question and sustained severe injuries. Shortly after being airlifted to a hospital, Tedford's blood and urine were tested, revealing the presence of amphetamines, opiates, benzodiazepines, and alcohol. Tedford's blood alcohol level was 142 mg/dL; the laboratory report noted that levels in excess of 100 mg/dL fall in the "may be intoxicated" range. In the exercise of the delegated discretion, CBSA denied Tedford's claims of more than $220,000 for medical bills and expenses. That decision was grounded in the plan provision that states "Benchmark shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." CBSA denied Tedford's claim after reviewing only written reports and records.

In pursuing an administrative appeal of the denial of benefits, Tedford's attorney wrote a letter to CBSA stating that "Kirk Tedford was not under the influence of narcotics when he was injured" and that "[a]ny narcotics in his system were result of medication" administered after the accide t. Tedford's counsel also advised CBSA that "Kirk Tedford was not intoxicated, and any alcoholic

beverage he consumed prior to his injuries did not cause those injuries." CBSA denied the administrative appeal.

Tedford then filed the instant action against his employer and Benchmark, the insurer, to recover for his medical bills and expenses. Only then did Benchmark investigate Tedfords representations that any narcotics in his system were administered by medical personnel after the accident, a fact confirmed by the expert retained by Benchmark.

The district court granted the defenants' motion for summary judgment.

I
SUMMARY JUDGMENT

We have reviewed de novo the appellate record in this summary judgment case, carefully considering the applicable facts, as well as the law as set forth in the opinion of the district court, the briefs of the parties, and the oral arguments of counsel. As a result, we are convinced that the district court was correct in all of its rulings and in its grant of summary judgment in favor of the defendants.

A. Standard of Review

Initially, Tedford urged the district court to review the plan administrator's determination de novo. Tedford advanced this position despite the fact of the plan's delegation of discretionary authority to CBSA and the settled law that in reviewing interpretation by a plan administrator vested with discretion, courts can consider only such evidence as was available to the administrator and must review it under the deferential, abuse-of-discretion standard. In ERISA cases, that standard requires that all interpretations of the plan and determinations of eligibility for benefits by the plan

administrator be affirmed unless found to be arbitrary or capricious.[1]

B. Conflict of Interest

Tedford asserted that Benchmark or CBSA, or both, have conflicts of interest in this matter. Tedford is incorrect. Benchmark remains an ERISA fiduciary but is bound to pay or deny claims based on CBSA's discretionary calls. CBSA is an arm's-length contractor, wholly independent of Future Employment and Benchmark. CBSA does not labor under any conflict of interest for purposes of ERISA, and thus is not subject to the sliding scale analysis under the rubric of our opinion in Vega v. National Life Ins. Servs.[2] The district court correctly determined that Tedford has demonstrated no legal or factual basis for claiming that any such conflict of interest was present.

C. Investigation

The district court was also correct in rejecting Tedford's claims of inadequate investigation by CBSA and lack of factual support of its ruling. We agree with the court's ultimate legal conclusion that "the summary judgment record does not demonstrate that Defendants acted arbitrarily and capriciously or committed an abuse of discretion in determining that Tedford's injuries were a consequence of circumstances that render him ineligible for coverage."

We need not address the remainder of Tedford's contentions; suffice it to say that we are not persuaded that

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[1]See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113-15 109 S.Ct. 948 (1989); Estate of Bratton v. National Union Fire Insurance Co., 215 F.3d 516 (5th Cir. 2000).

[2]188 F.3d 287 (5th Cir. 1999)(en banc).

the district court erred in rejecting those contentions and dismissing Tedford's action.

II

ATTORNEY'S FEES

As counter-appellants, the defendants seek reversal of the district court's refusal to award them attorneys' fees and costs pursuant to § 502(g) of ERISA. (29 U.S.C. §1132(g)(1)). We review the district court's denial of defendant's request for attorneys' fees for abuse of discretion. Lain v. Unum Life Insurance Co., 279 F.3d 337, 343 (5thCir. 2002).

In analyzing defendants' request for attorney's fees, the district court applied the five factors announced in Iron Workers Local No. 272 v. Bowen[3]:

> (1) The degree of the opposing parties' culpability or bad faith;
> (2) the ability of the opposing parties to satisfy an award of attorney's fees;
> (3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;
> (4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant question regarding ERISA itself; and
> (5) the relative merits of the parties' position.
>
> "No one of these factors is necessarily decisive, and some may not be apropos in a given case, but together they are the nuclei of concerns that a court should address in applying section 502(g)." Id.

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[3]624 F.2d 1255, 1266 (5th Cir. 1980).

The first Bowen factor examines the degree of the opposing party's culpability or bad faith. The district court concluded that there was no evidence that Tedford acted in bad faith, but the court did not conduct a detailed analysis of Tedford's culpability, despite the disjunctive nature of the first Bowen factor. However, it is readily apparent that the district court considered and rejected the conclusion that Tedford was culpable. In evaluating his claims, the district court concluded that Tedford presented "legitimate, albeit ultimately unsuccessful complaints regarding the way in which his case was handled, the completeness of the administrative record, and the manner in which his concerns and those of his attorney were addressed." Such complaints are not frivolous in nature. Additionally, in analyzing the third Bowen factor, i.e., whether an award of fees would deter persons acting under similar circumstances, the district court noted that that factor "carries less force because there is no finding of bad faith or culpability so that there is less negative behavior for an award of fees to deter." Considering the district court's opinion as a whole, and the deference to which the district court's decision is entitled, the court did not abuse its discretion in concluding that the first factor did not weigh in defendants' favor.

We note that although the first factor is phrased disjunctively ("culpability" and "bad faith") the definitions of the terms "culpability" and "bad faith" are similar, and thee is apparently no Fifth Circuit precedent explaining the difference, if any, between the two terms in this context. As used in *Bowen*, 642 F.2d at 1266, the terms may have been used synonymously.

As for the second factor (the ability of the opposing party to satisfy an award of attorneys' fees,) the district

court correctly concluded that this factor did not weigh in favor of an award of attorneys' fees. The record contains no evidence indicated that Tedford, faced with significant unreimbursed medical expenses, has the resources to satisfy an award of attorneys' fees.

Considering our analysis of the merits of Tedford's claims there can be no doubt that the district court correctly weighed the fifth Bowen factor in favor of defendants.

The district court also concluded that the third factor (whether an award of attorneys' fees against the opposing party would deter persons acting under similar circumstances) weighed in favor of an award of attorneys' fees. However, the district court accorded that factor less weigh in ultimately determining defendants' entitlement to attorneys' fees, concluding that Tedford's lack of bad faith or culpability meant that there was "less negative behavior for an award of attorneys' fees to deter." We find no fault in that analysis. In Harms v. Cavenham Forest Industries., Inc., 984 F.2d 686, 694 n. 12 (5th Cir. 1993), this court recognized that there is a "lack of bad faith or culpability" in the pursuit of the claim for ERISA benefits "the deterrent purpose that the third *Bowen* factor purports to serve" is applicable.

Defendants concede that the fourth Bowen factor has little relevance. Accordingly, we do not consider it.

The district court concluded "that the collective circumstances do not favor an award of attorneys' fees." We find that the district court did not abuse its discretion in denying an award of attorneys' fees.

We AFFIRM the judgment of the district court.

THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

KIRK TEDFORD,	§	
PLAINTIFF,	§	
	§	
VS.	§	CIVIL ACTION NO.
	§	4:00CV- 1695-BE
	§	
BENCHMARK	§	
INSURANCE CO., ET AL.	§	
DEFENDANTS.	§	

MEMORANDUM OPINION AND ORDER

Plaintiff Kirk Tedford has filed suit against Defendants Benchmark Insurance Company and the employee benefits plan sponsored by his previous employer, Future Equipment Company, Inc. for the denial of health care insurance benefits. The parties have filed cross-motions for summary judgment. Having reviewed the arguments and summary judgment record, the court finds that Defendants' Motion for Summary Judgment is meritorious and that Plaintiff's Motion for Summary Judgment should be denied.

A. FACTS AND PROCEDURAL HISTORY

Kirk Tedford was a participant in an employee welfare benefit plan established by his employer, Future Equipment Company, Inc. Future Equipment purchased a health insurance policy from underwriter Benchmark Insurance Company. Benchmark assigned the responsibility for claims administration under the policy to

a third company, Corporate Benefit Services of America, Inc. (CBSA). Benchmark granted CBSA discretionary authority in processing and settling insurance claims for Future Equipment employees. (Def. Mot. Summ. J., App., Ex. A).

Tedford was involved in a one-vehicle motorcycle accident on November 6, 1999 at approximately 12:05 am. (Def. Mot. Summ. J., App., Ex. D-3, p. 322). Tedford was thrown from his motorcycle and sustained a serious head injury. He was airlifted to a local hospital, underwent surgery and remained unconscious for three weeks.

Tedford was given blood and urinalysis tests at approximately 12:30 a.m. on November 6, 2000. Tedford tested positive for amphetamines, opiates, benzodiazepines, and alcohol. (Def. Mot. Summ. J., App., Ex. D-4, p. 335). His blood alcohol level was measured at 142mg/dL. Any amount over 100 ml/dL is referred to as "may be intoxicated" on the laboratory report.(Def. Mot. Summ. J., App., Ex. D-4, p. 335). The laboratory report cautioned that the results were for medical purposes only and not a forensic order. (Def. Mot. Summ. J., App., Ex. D-4, p. 334).

Upon his release from the hospital, Tedford filed a claim with CBSA to recover his hospital bills expenses totaling more than $220,000. After reviewing the accident report and medical records provised by Harris Methodist Hospital, including the toxicology report, CBSA denied benefits to Tedford based on the following provisions in his medical benefits plan:

XI. General Exclusions

. . . .

TT. Health care services resulting or arising from complications of, or incidental to, any health care service not covered under the policy.

. . . .

XVI. General Provisions

. . . .

U. Intoxicants and Narcotics

Benchmark shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(Def. Mot. Summ. J., App., Ex. D-1, pp. 96, 112).

CBSA sent a letter to Tedford on March 21, 2000 denying his benefits. (Def. Mot. Summ. J., App., Ex.B). Tedford filed an appeal with CBSA on April 24, 2000, (Def. Mot. Summ. J., App., Ex. D-5), which CBSA also denied based on the toxicology report and the policy exclusions. (Def. Mot. Summ. J., App., Ex. C). Tedford insists that CBSA abused its discretion in determining his ineligibility for benefits and failed to evaluate all the relevant evidence in denying his claim. Tedford filed suit to recover his benefits in the amount of his medical bills plus reasonable attorney's fees. Benchmark filed a Motion for Summary Judgment and Tedford has responded with his own Motion for Summary Judgment.

B. STANDARDS OF REVIEW

Summary judgment is appropriate if the pleadings, depositions, answers to interrogations, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c); *Celotex Corp. v. Catrett,* 477 U.S. 317, 322,

106 S.Ct. 2548, 2552, 91 L.Ed.2d 265 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247, 106 S.Ct. 2505, 2509-10, 91 L.Ed.2d 202 (1986).

It is undisputed that Future's employee health insurance program is an employee welfare benefit plan as defined and governed by the provisions of the Employee Retirement Income Security Act (ERISA). *See generally* 29 U.S.C. §§ 1002(1), 1003(a). Nor do the parties dispute that ERISA preempts any state law claims insofar as they relate to an employee benefit plan subject to ERISA. 29 U.S.C. § 1144(a); *Pilot Life Ins. Co. v. Dadeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Instead, when a beneficiary or participant like Tedford wants what he alleges was supposed to have been distributed under the plan, the appropriate remedy is a claim for denial of benefits under the civil enforcement provisions of ERISA. *See* 29 U.S.C. § 1132(a)(1)(B).

Consistent with established principles of trust law, a denial of benefits challenged under § 1132(a)(1)(B) is reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113-15, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989); *Estate of Bratten v. National Union Fire Ins. Co.*, 215 F.3d 516 (5th Cir. 2000). For purposes of reviewing plan interpretations when the administrator has discretion, the court considers only the evidence that was available to the administrator; but in reviewing interpretations of a plan under *de novo* standard, the court can consider additional evidence that was unavailable to the administrator, *Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 102 (5th Cir. 1993).

Understandably, the Defendants urge that the abuse of discretion standard applies, while Tedford urges that the court should review the denial of benefits *de novo*. Tedford observes that in both the Certificate of Group Insurance and the Subscription Agreement signed by Future, Benchmark denied having any agency relationship with the employer, disclaimed serving in any capacity for purposes of ERISA, and attempted to distance itself, the insurance trust, and its delegated claims administrator from any duties imposed by ERISA. (Def. Mot. Summ. J., App., pp. 34, 37)

The validity of these disclaimers is questionable at best, and in fact, the Defendants now assert that their own disclaimers are void. A disclaimer of the role of plan administrator may be permissible because when no administrator is specifically designed by the plan, the plan sponsor becomes the plan administrator by statute.[1] 29 U.S.C. § 1002(16)(A)(ii), (B). But attempts to renounce a fiduciary role do not appear to be authorized by ERISA. To the contrary, except in limited circumstances not applicable here, a provision in an agreement or instrument purporting to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under ERISA is void as against public policy. 29 U.S.C. § 1110(a). *Cf. Custer v. Pan Am. Life Ins. Co.* 12 F.3d 410, 418 n.3 (4th Cir. 1993)(noting that contractual disclaimer of ERISA fiduciary status should not be determinative, discretionary functions performed should control).

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[1]Although the plan sponsor (usually the employer) becomes the plan administrator unless the terms of the plan designate otherwise. Future Equipment retained no discretion in the contractual administration of the policy, and explicitly advised Tedford that it had no say in the denial of his claim. (Plf. App., Tab 10)

A person is a fiduciary with respect to a plan to the extent that person (1) exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets; (2) renders investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of such plan, or has any authority or responsibility to do so; or (3) has any discretionary authority or discretionary responsibility in the administration of such plan. *See* 29 U.S.C. §§ 1002(21)(A)(1999). Under the terms of the insurance policy and related documents in this case, Benchmark reserved the sole and exclusive right to interpret and apply the policy provisions, including the right to make factual determinations, and granted itself the discretion to delegate some of its authority to other persons or entities for administrative purposes, i.e., CBSA.[2] (Def. Mot. Summ. J. App., Ex. D-1, pp. 40-41).

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[2]Tedford correctly notes that CBSA's authority was not co-extensive with Benchmark's. Benchmark did retain some control with regard to the payment of large claims by providing in its agreement with CBSA that

> any single health claim payment in the amount of $10,000 to $24,999 shall be sent to the Company for review after being pain[sic], while any single health claim payment in the amount of $25,000 for [sic] more shall require the Company's [Benchmark's] prior approval before being paid. For any claiment where the diagnosis is such to indicate that the total health claims cost may exceed $50,000, the situation shall be brought to the immediate attention of the Company when Administrator [CBSA] receives notice of the diagnosis.

This provision does not appear to limit CBSA's authority to issue a denial of a particular claim, nor does Benchmark protest that CBSA

This authority bestows fiduciary status on these entities under ERISA definition.

Tedford displays outrage that Benchmark seeks to circumvent its contractual disclaimers of any ERISA responsibility and secure to itself and the plan the more beneficial abuse of discretion standard of review for its plan interpretations.[3] Although a lengthy assessment of public policy concerns could be entertained, such a discussion would be pointless given the true nature of the parties' disagreement. They do not present sophisticated arguments about the correct interpretation of the exclusionary clause or other policy provisions, but center their dispute on the Defendants' factual determinations that Tedford's injuries were a consequence of intoxication or the influence of illegal narcotics. (*See* Plf. Brief 6/28/01, p. 27).

Regardless of the discretion, if any, that the plan grants to its administrator of fiduciaries to interpret the plans terms, the Fifth Circuit holds that factual determinations under ERISA plans are to be reviewed under an abuse of discretion standard. *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F2d 1552, 1562 (5th Cir. 1991), *cited in Bratton*, 215 F3d at 523. The Fifth

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acted outside the approved limits on its authority.

[3]Benchmark also asserts that only the plan is a proper party in this action pursuant to ERISA's civil enforcement provisions, which provide that "[a]n employee benefit plan may sue or be sued [ ] as an entity." 29 U.S.C.§1132(d). But Defendants cite no authority for the proposition that the plan is the only legitimate defendant in any given case. Benchmark issued the policy and retained almost complete control of the claims process, although it delegated much of its authority to CBSA as claims administrator, and now concedes its role as a fiduciary. Benchmark is a proper party.

Circuit distinguishes *Bruch* as limited to matters of plan interpretation when the facts are not in dispute, and ruled that the federal courts owe due deference to factual determinations made during the benefit review process. *Bratton*, 215 F.3d at 522; *Pierre*, 932 F.2d at 1562. Because Tedford is contesting findings that are factual rather than interpretive in nature, an abuse of discretion standard is appropriate.

C. DISCUSSION

ERISA requires that a claimant be informed of the specific reasons for the denial of his claim, with specific reference to the plan provisions relevant to the denial, and be given opportunity for a full review. *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 393-94 (5th Cir. 1998). CBSA notified Tedford in March 2000 that his claim was denied because of the policy exclusions for injuries sustained as a consequence of intoxication or the use of narcotics. (Def. Mot. Summ. J., App., Ex. B). Tedford appealed, but by letter dated July 22, 2000, CBSA again denied his claim based on the same exclusionary provisions. CBSA referred Tedford to the hospital toxicology report and the accident report prepared by the local police department. (Def. Mot. Summ. J., App., Ex. C).

In reviewing whether there has been an abuse of discretion, the court must analyze whether the plan administrator acted arbitrarily or capriciously in making his determination.[4] *Sweatman v. Commercial Union Ins.*

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[4]There is some debate regarding whether the abuse of discretion standard is equivalent to an arbitrary and capricious standard, but the more prevalent view tends to consider it a semantic as opposed to a substantive difference. *See, e.g., Meditrust Financial Servs. v. Sterling Chem.*, 168 F.3d 211, 214-15 (5th Cir. 1999);

Co., 39 F.3d 594, 600 (5th Cir. 1994). A decision is arbitrary only if made without a rational connection between the known facts and the decision or between the found facts and the evidence. *Meditrust Fin. Servs. v. Sterling Chem.*, 168 F.3d 211, 215 (5thCir. 1999) (quoting *Bellaire Gen. Hosp. V. Blue Cross Blue Shield*, 97 F.3d 822, 828 (5thCir. 1996). If a denial is supported by substantial evidence and is not erroneous as a matter of law, it is not arbitrary or capricious. *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 637 n. 12 (5th Cir. 1992).

Because a decision whether an abuse of disecration has occurred is based upon information known to the administrator at the time he made the decision, the court is generally confined to the record available to the administrator when reviewing the factual determinations underlying denial of a claim. *Vega v. National Life Ins. Servs., Inc.,* 188 F.3d 287, 299 (5thCir. 1999)(en banc);*Meditrust*, 168 F.3d at 215; *Schadler*, 147 F.3d at 395. Of course, the court owes no deference to an administrator's unsupported suspicions. *Vega*, 188 F.3d at 302.

Tedford contends that CBSA suffers from a conflict of interest that requires a more rigorous review of its determinations. The Fifth Circuit has adopted a "sliding scale" approach in reviewing the determinations of a self-interested fiduciary. *Vega,* 188 F.3d at 297. Although the standard remains one of abuse of discretion, the conflict is a factor to be considered: The greater the conflict, the less deferential the court's review will be. *Bruch*, 489 U.S. at 115, 109 S.Ct. at 957; *Vega*, 188 F.3d at 297. Tedford, however, has demonstrated no basis for finding a conflict

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Wildbur v. ARCO Chem. Co., 974 F.2d 631, 635 (5th Cir. 1992).

of interest. Tedford observes that CBSA fills several roles and performs multiple functions with regard to the Future Equipment employee benefit plan, but he fails to identify what financial benefit CBSA can expect to gain that would encourage it to deny a claim filed under the plan. CBSA appears to have a purely contractual arrangement between itself and the insurer, Benchmark, that would not create an inference of a conflict of interest. Cf. *Vega*, 188 F.3d at 295, 301. CBSA's schedule of fees for administering Benchmark's insurance policies are generally scaled to the volume of work, the number of plan participants, and the number of hours worked processing or administering claims. Tedford's reasoning that CBSA must be conflicted because of its multiple roles in the administration of the plan is unpersuasive and does not require that a materially lesser level of deference be afforded to CBSA's determinations.

Tedford also criticizes CBSA for conducting an inadequate investigation during the benefit review process, and most notably, for failing to obtain or properly review the Careflight report documenting the emergency treatment he received when he was airlifted from the scene of the accident to the hospital. Additionally, Tedford complains of CBSA's failure to interview him or his attorney about the accident.[5] There is no specific duty to conduct a reasonable or good faith investigation, but as a safeguard, a claimant, a claimant or his attorney may add evidence to the administrative record by submitting it in a manner that gives the administrator a fair opportunity to consider it.[6] *Vega*, 188 F.3d at 298, 300. *See also Gooden*

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[5]Tedford has no memory of the accident. (Plf. App., Tab 20).

[6]Additionally, ERISA provides for the full and fair review of

v. Provident Life & Accident Ins. Co., 250 F.3d 329, 333 (5th Cir. 2001); *Bratton*, 215 F.3d at 512 F.3d at 521 & n.5. If the claimant submits additional evidence to the administrator and requests a reconsideration of his claims, the new evidence is considered part of the administrative record. *Vega*, 188 F.3d at 300.

The court's focus, however, is not on the underlying investigation. Instead, the Fifth Circuit has directed the district courts to consider whether the record that was developed adequately supports the administrative determination. *Vega*, 188 F.3d at 298. The administrator is obligated to identify the evidence in the administrative record, and the claimant may challenge its completeness,[7] but once the administrative record is determined, the district court may not stray from it except in limited circumstances. *Id.* at 299. The only exceptions are for evidence related to how the administrator has interpreted terms of the plan in other instances, or evidence (including expert evidence) to assist the court in understanding medical terminology or procedures. *Id.* The court may not receive outside evidence to resolve disputed material facts,

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any denied claim, 29 U.S.C. §1133(2), but the failure to comply with this provision does not warrant a heightened level of scrutiny-although it may be evidence supporting a finding of abuse of discretion. *Sweatman*, 39 F.3d at 598 & n. 5. Here, CBSA did conduct a review of its initial denial of Tedford's claim at his request and afterwards issued a written decision affirming the denial of benefits.

[7]Tedford has several criticisms of the "administrative record" that the Defendants have provided as part of their summary judgment evidence, and those criticisms will be addressed as relevant to a resolution of the pending motions.

i.e., facts the administrator relied upon to resolve the merits of the claim itself. *Id.*

Tedford asserts that the reason he tested positive for opiates and amphetamines was because of medications given to him by the emergency response team during the helicopter flight to Harris Methodist Hospital. The Careflight report reveals that Tedford was given several medications en route to the hospital (and before being tested), but CBSA either did not have this report or did not appreciate its import prior to denying Tedford's claim. (Plf. App., Tab 14, pp. 123-25). Both Tedford and Benchmark have strayed from the administrative record to supply the court with the March 2001 expert report of toxicologist Eric Comstock, the Defendants' retained expert, who has opined that the positive drug findings were probably cross-reactions or otherwise attributable to the medical treatment Tedford received following the accident .(Def. Reply, App. at 1; Plf. App., Tab 8). The report was prepared after litigation ensued, it was not available to the Defendants at the time the decision to deny benefits was made, and bears on a material issue that Defendants had to resolve in denying Tedford's claim. But even accepting the report as admissible evidence that aids in understanding the relevant medical process, the report does not contradict Tedford's serum blood alcohol analysis that revealed a level of 142 milligrams of alcohol per deciliter of blood. According to Comstock, this blood serum level equates to a probable blood alcohol level between .10% and 14%, and nothing in the treatment records would suggest that the level was due to anything

other than the ingestion of alcoholic beverages.[8] (Def. Reply, App. at 2; Plf. App., Tab 8).

Tedford contends that Mississippi law controls the issue of his intoxication, and that Mississippi forbids using the results of a chemical analysis to deny benefits under an insurance policy. MISS. CODE ANN. §63-11-45 (prohibiting denial of insurance coverage because of test results or refusal to submit to test under implied consent law). Conversely, Defendants urge that ERISA preempts all state law in this instance, but if not, Texas law controls.[9] ERISA preempts all state laws that "relate to" an employee benefit plan except for state laws that regulate insurance. *See generally* 29 U.S.C. §1144(a)-(b)(2)(A). A law regulates insurance when (1) it is specifically directed at the insurance industry; (2) it transfers or spreads policyholder risk; and (3) it affects an integral part of the policy relationship between insurer and insured.[10] *Pilot Life*, 481 U.S. at 48-49, 107 S.Ct. At

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[8]Tedford challenges the completeness and disorder of the administrative record that Defendants have presented to the court, and the courts agrees that the documentation is not a model of organization. But neither the additional documents Tedford now submits as being part of the proper record or his allegations create a material fact issue about the reasonable basis for the determinations relating to his intoxication and the accident or undermine the Defendants' exercise of discretion in denying his claim.

[9]Alternatively, Defendants assert that Texas law should control. This assertion is contrary to Defendants' admission in response to the Interrogatories propounded by Tedford that Mississippi law would control unless preempted.

[10]In addition, when the insurance policy in dispute is part of a plan governed by ERISA, but ERISA does not expressly address the issue presented, then the court must devise federal common law to resolve the parties' dispute and in doing so, may look to state law for

1553-54. But regardless of whether the cited Mississippi law may otherwise survive preemption, it is inapplicable in the instant case. Tedford is relying on Mississippi motor vehicle laws governing public safety procedures and related criminal penalties for a person suspected of driving under the influence of alcohol or controlled substances. He cites no authority for the proposition that criminal provisions relating to breathalyser or blood alcohol testing done by or at the discretion of law enforcement are relevant when he was tested for intoxicants and narcotics by medical personnel and for treatment purposes. Neither ERISA nor the plan provisions require an arrest or conviction of an alcohol-related offence to deny benefits to an injured party. Further, both Texas and Mississippi insurance laws specifically permit and insurer to include an exclusionary provision for intoxication identical to the provision included in the Benchmark policy. *See* MISS. CODE ANN. §83-9-5(2)(h); TEX. INS. CODE ANN. art. 3.70-3(B)(9).

Tedford cannot recall the details of his accident and does not dispute drinking alcohol at some point before his accident-although he denies that he was intoxicated or that intoxication was the cause of the accident, but the exclusionary provision in the policy is not ambiguous and Tedford has created no fact question about Defendants' decision to apply the exclusion to his claim. Although the police report does not indicate that the accident investigator suspected alcohol was a factor, it reflects that

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guidance so long as the state law is not inconsistent with congressional policy concerns. *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448 (5th Cir. 1995); ; *Brandon v. Travelers Ins. Co.*, 18 F.3d 1321, 1325 (5th Cir. 1994); *Pitts v. American Sec. Life Ins. Co.*, 931 F.2d 351, 355 (5th Cir. 1991).

the accident was a one-vehicle accident occurring on a clear night[11] and on a smooth, dry road as Tedford exited from a freeway and hit the curb as he attempted to enter the service road. The Defendants had a reasonable basis for finding that Tedford's losses were sustained or contracted as a consequence of his intoxication in light of the toxicology evidence and the circumstances of the accident. Although the court might have reached a different conclusion, the guiding principle is whether the decision made falls somewhere on a continuum of reasonableness–even if on the low end. *Vega*, 188 F.3d at 297.

Tedford's situation invokes sympathy, but the summary judgment record does not demonstrate that Defendants acted arbitrarily and capriciously or committed an abuse of discretion in determining that Tedford's injuries were a consequence of circumstances that rendered him ineligible for coverage. Summary judgment is appropriately granted for the Defendants.

D. ATTORNEY'S FEES

The Defendants have asked the court to award them attorney's fees in defending this action. ERISA grants the court discretion to allow a reasonable attorney's fees and costs to either party in a civil enforcement action. 29 U.S.C.§1132(g)(1). The Fifth Circuit utilizes a five-factor test for determining whether an award of attorney's fees is appropriate, and considers: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the

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[11]The accident investigator who prepared the police report erroneously indicated the accident occurred at "0005 P.M." which CBSA initially understood as referring to five o'clock in the evening; however, the accident actually occurred closer to midnight. (Def. Mot. Summ. J., Ex. D-3).

opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing party would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties [sic] positions. *See Wegner v. Standard Ins. Co.*, 129 F.3d 814, 821-822 (5thCir. 1997); *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1266 (5th Cir. 1980). *See also Todd v. AIG Insur. Co.*, 47 F.3d 1448, 1459 (5th Cir. 1995). No one single factor is necessarily decisive, and some may not be apropos at all in a given case, but together they are the core concerns that a court should address. *Wegner*, 129 F.2d at 821; *Iron Workers Local No. 272*, 624 F.2d at 1266.

The first factor identified by the Fifth Circuit relates to culpability, but does not weigh in Benchmark's favor because there is no evidence that Tedfor has acted in bad faith. Tedford has presented legitimate, albeit ultimately unsuccessful, complaints regarding the way in which his case was handled, the completeness of the administrative record, the manner in which his concerns and those of his attorney were addressed. The second factor, Tedford's ability to pay for these attorney's fees, likewise does not support an award to Benchmark. Tedford was out of work for an extended time and has considerable debt involved with his accident. The very reason for his claim against Benchmark was to clear these debts and recover his medical expenses. Although Defendants state that Tedford is capable of paying the fees, no documentation supports their assertion. This factor weighs heavily against an award of fees.

The third factor, pertaining to deterrence, and the fifth factor, which concerns the relative merits of the parties' positions, weigh in favor of awarding Defendants their attorney's fees as evidenced by the granting of summary judgment to the Defendants. The third factor, however, carries less force because there is no finding of bad faith or culpability so that there is less negative behavior for an award of fees to deter. *Cf. Hixson v. Liberty Corp.*, 964 F.Supp. 218, 227 (W.D. La. 1997)(finding that award of fees would not serve as deterrence for future negative conduct because there was no finding of bad faith on part of party against whom the award was sought).

Defendants submit that the fourth factor has little relevance because this is not an action on behalf of other participants or beneficiaries of Future's benefit plan, and no significant question about ERISA itself is in dispute. This factor does not weigh heavily in the consideration of Defendants' request for an award of their attorney's fees.

Upon consideration of all of the foregoing factors, the court finds that the collective circumstances do not favor an award of attorney's fees and that Defendants' request for recovery of their accrued attorney's fees should be denied.[12]

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[12]Additionally, the request for attorney's fees is not supported by sufficient evidence. If an award of fees is deemed appropriate, then the amount of fees is calculated using the lodestar method of reasonable hours worked multiplied by the reasonable hourly rates of the attorneys. *Louisiana Power and Light v. Kellstrom*, 50 F.3d 319, 324 (5th Cir. 1995). The party requesting the fees has the burden of establishing the number of attorney hours expended, and can meet that burden only by presenting adequate evidence from which the court can determine what hours should be included in the reimbursement. *Kellstrom*, 50 F.3d at 324. This type of evidence usually includes contemporaneous billing records, detailed

It is ORDERED that Defendants' Motion for Summary Judgment is granted, except that their request for attorney's fees is denied. Plaintiff's Motion for Summary Judgment is denied.

SIGNED JULY 20, 2001.

/s/
CHARLES BLEIL
UNITED STATES
MAGISTRATE JUDGE

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descriptions of hours worked, and hourly rates. *Id.* Defendants provide an affidavit from counsel asserting only that Benchmark has incurred a total of $18,616.50 in attorney's fees to date and $1,070.49 in costs in defending this action. The documentation does not meet the standard set out by *Kellstrom*. *See also Wegner*, 129 F.3d at 822.

SEC. 402. ESTABLISHMENT OF PLAN.

(a) Named Fiduciary.–

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this title, the term "named fiduciary" means fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

SEC. 404. FIDUCIARY DUTIES.

(a) Prudent Man Standard of Care.–

(1) Subject to §§403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) Providing benefits to participants and their beneficiaries; and

* * * *

(B) with care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims:

* * * *

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with provisions of this title and title IV.

SEC. 503. CLAIMS PROCEDURE.

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.